



Indiana State Department of Health

Division of Long Term Care

APPLICATION FOR NEW FACILITY TITLE 19 NF

TO: Applicant

FROM: Program Director-Provider Services
Division of Long Term Care

This letter is to inform applicants of the required documentation for application for participation in Medicaid Program. For additional information on the rules and regulations involving this action please refer to:

<http://www.in.gov/isdh/regsvcs/ltc/lawrules/index.htm>

An application should include the following forms and/or documentation:

1. State Form 8200, Application For License To Operate A Health Facility, to include required attachments (State Form 8200 enclosed);
2. State Form 19733, Implementing Indiana Code 16-28-2-6 (enclosed);
3. Documentation of the applicant entity's registration with the Indiana Secretary of State;
4. State Form 51996, Independent Verification Of Assets And Liabilities, to include required attachments (State Form 51996 enclosed);
5. Completed Form CMS-671, Long Term Care Facility Application for Medicare and Medicaid (enclosed);
6. Two (2) signed originals of the Form HHS-690, Assurance of Compliance (enclosed);
7. State Form 4332, Bed Inventory (enclosed);
8. Facility floor plan on 8 ½" x 11" paper to show room numbers and number of beds per room;
9. Copy(s) of the Patient Transfer Agreement between the facility and local hospital(s);
10. A copy of the facility's Quality Assessment and Assurance Committee policy;
11. A proposed staffing plan based upon 20%, 50% and 100% occupancy, to ensure staffing will be in accordance with federal regulations;
12. An proposed two-week staffing schedule to demonstrate compliance with federal regulations (include all RN, LPN, CNA and QMA hours);
13. Staffing plan to include the number, educational level, and personal health of employees;
14. Copies of all contracts or agreements for services to cover the full range of services to be offered to residents, to include copies of licenses/certification, if applicable, for individual professionals providing services; and
15. Copy of the facility's disaster plan.

NOTE: The facility must contact EDS, the State Medicaid Agency Contractor, to obtain a Provider Enrollment Agreement for Medicaid participation. This should be submitted directly back to EDS for processing.

The following is a general outline of the application process (in approximate chronological order):

1. Submit plans and specifications for new construction or an existing building to the Indiana State Department of Health, Division of Sanitary Engineering for review and approval;
2. Once plans and specifications have been approved, and new construction or remodeling of an existing building is substantially complete, please submit a copy of the architect's Statement of Substantial Completion Request for Inspection, State Form 13025 (or A1A G407), or a letter indicating that the construction is substantially complete, to the Program Director-Provider Services, Division of Long Term Care;
3. Submit the following documents in order for the Division of Long Term Care to grant authorization to occupy the facility:
 - (1) Completed State Form 8200, Application For License To Operate A Health Facility, to include all required attachments;
 - (2) Documentation of the applicant entity's registration with the Indiana Secretary of State;
 - (3) Completed State Form 51996, Independent Verification of Assets and Liabilities, to include required attachments;
 - (4) Request for the applicable fire safety inspections (Life Safety Code, Sanitarian and/or State Fire Code) to the Program Director-Provider Services, Division of Long Term Care;
4. Once the applicable fire safety inspections have been conducted and released, the Division of Long Term Care will issue an Authorization to Occupy letter to the applicant (*residents may be admitted upon receipt of this authorization; however, please be advised that the facility will not be able to bill Medicaid for services rendered prior to the initial certification survey and official program acceptance*);
5. Prior to the initial licensure and certification surveys, the Division must approve all application documents submitted;
6. Once these requirements are satisfied, and the facility has provided skilled care to at least two (2) comprehensive residents, the facility may submit a written request to the Program Director-Provider Services for the initial licensure and certification surveys (*every effort will be made to conduct these surveys within 21 days of the date you indicate your readiness for survey*);
7. Upon completion of your initial licensure and certification surveys, the Division of Long Term Care will forward your application to the State Medicaid Agency along with your initial certification survey results;
8. The State Medicaid Agency will notify you in writing of their final determination for acceptance or denial into their respective programs, with the effective participation dates.

Please do not hesitate to contact me at 317/233-7794 should you have questions regarding the application process.

Enclosures

Revised March 2005



APPLICATION FOR LICENSE TO OPERATE A HEALTH FACILITY

(Pursuant to IC 16-28 and 410 IAC 16.2)

State Form 8200 (R3/8-00)

Indiana State Department of Health-Division of Long Term Care

DIVISION OF LONG TERM CARE

Date Received _____

Date Approved _____

Approved by _____

Please Print or Type

SECTION I - TYPE OF APPLICATION

Application (check appropriate item)

☐ Change of Ownership (Anticipated date of Sale/Purchase/Lease) _____ ☐ New Facility ☐ Other _____

SECTION II - IDENTIFYING INFORMATION

A. Practice Location (facility)

Name of Facility _____

Street Address _____

P.O. Box: _____

City _____

County _____

Zip Code +4 _____

Telephone Number
() () _____

Fax Number
() () _____

Facility's Cost Reporting Year

From (mm/dd): _____

To (mm/dd): _____

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) The licensee and the applicant entity as described in Item IV-A of this application should be the same.

Street Address _____

P.O. Box _____

City _____

State _____

Zip Code+4 _____

Telephone Number
() () _____

Fax Number
() () _____

EIN Number _____

Fiscal Year End Date

(mm/dd) _____

C. Building Information

1. Status of building to be used (check appropriate item)

☐ Proposed New Construction ☐ Alteration of Existing Building ☐ Existing Licensed Health Facility ☐ Other _____

2. Type of Construction (materials) (if new, as certified by architect or engineer registered in the state of Indiana)

D. Type of Services to be Provided			
1. Level of Care	Number of Beds in Each Category (to be licensed)	2. Certification Designation	Number of Beds in Each Category (to be licensed)
<input type="checkbox"/> Residential	_____	<input type="checkbox"/> SNF (Title 18 – Medicare)	_____
<input type="checkbox"/> Comprehensive (Certified)	_____	<input type="checkbox"/> SNF/NF (Title 18 – Medicare/Title 19 – Medicaid)	_____
<input type="checkbox"/> Comprehensive (Non-certified)	_____	<input type="checkbox"/> NF (Title 19 – Medicaid)	_____
<input type="checkbox"/> Children's Facility	_____	<input type="checkbox"/> ICF/MR	_____
<input type="checkbox"/> Developmentally Disabled	_____		_____
Total Number of Licensed Beds		Total Certified Beds	

SECTION III – STAFFING

A. Administrator		
Name (enter full name)		
Indiana License Number (please include a copy of license with application)	Date of Birth	Date employed in this position
<p>1. List post secondary education and health related experience</p> <p>_____</p> <p>_____</p> <p>_____</p>		
<p>2. On a separate sheet, list the facilities in Indiana, or any other state, in which the Administrator has been previously employed, including the dates of employment and reason for leaving. Identify on this list any of these facilities which were operating with less than a full license at the time the Administrator was employed.</p>		
<p>3. Has the administrator ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state on a separate sheet the facts of each case completely and concisely)</p>		
<p>4. Has the administrator's license ever lapsed, been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes, state on a separate sheet the facts of each case completely and concisely)</p>		
<p>5. Is the administrator presently in good health and physically able to fully carry out all of the duties in the operation of this health facility? <input type="checkbox"/> Yes <input type="checkbox"/> No (If no, explain on a separate sheet)</p>		
B. Director of Nursing		
Name (enter full name)		
Indiana License Number (please include a copy of license with application)	Date of birth	Date employed in this position
Education (Name of School of Nursing)		
School Degree	Year Graduated	
Other College Education		
Qualifications or Experience		

1. Has the Director of Nursing ever been convicted of any criminal offense related to a dependent population? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, state on a separate sheet the facts of each case completely and concisely)</i>																		
2. Has the Director of Nurse's License ever lapsed, or ever been suspended or revoked? <input type="checkbox"/> Yes <input type="checkbox"/> No <i>(If yes, state on a separate sheet the facts of each case completely and concisely)</i>																		
SECTION IV - DISCLOSURE OF OWNERSHIP AND CONTROLLING INTEREST STATEMENT (In compliance with the Indiana Health Facilities Rules (410 IAC 16.2))																		
A. Applicant Entity																		
Name of Applicant Entity <i>(operator(s) of the facility)</i>																		
D/B/A <i>(Name of Facility)</i>																		
B. Ownership Information																		
List names and addresses of individuals or organizations having direct or indirect ownership interest of five percent (5%) or more in the applicant entity. Indirect ownership interest is interest in an entity that has an ownership interest in the applicant entity. Ownership in any entity higher in a pyramid than the applicant constitutes indirect ownership. <i>(use additional sheet if necessary)</i>																		
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 40%;">Name</th> <th style="width: 40%;">Business Address</th> <th style="width: 20%;">EIN Number</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td></tr> </tbody> </table>	Name	Business Address	EIN Number															
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C. Type of Change of Ownership																		
<table style="width: 100%;"> <tr> <td><input type="checkbox"/> Assignment of Interest</td> <td><input type="checkbox"/> Lease</td> <td><input type="checkbox"/> Merger</td> <td><input type="checkbox"/> New Partnership</td> </tr> <tr> <td><input type="checkbox"/> Sale</td> <td><input type="checkbox"/> Sublease</td> <td><input type="checkbox"/> Termination of Lease</td> <td><input type="checkbox"/> Other _____</td> </tr> </table>	<input type="checkbox"/> Assignment of Interest	<input type="checkbox"/> Lease	<input type="checkbox"/> Merger	<input type="checkbox"/> New Partnership	<input type="checkbox"/> Sale	<input type="checkbox"/> Sublease	<input type="checkbox"/> Termination of Lease	<input type="checkbox"/> Other _____										
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D. Type of Entity																		

<u>For Profit</u>	<u>NonProfit</u>	<u>Government</u>
<input type="checkbox"/> Individual	<input type="checkbox"/> Church Related	<input type="checkbox"/> State
<input type="checkbox"/> * Partnership	<input type="checkbox"/> Individual	<input type="checkbox"/> County
<input type="checkbox"/> ** Corporation	<input type="checkbox"/> * Partnership	<input type="checkbox"/> City
<input type="checkbox"/> *** Limited Liability Company	<input type="checkbox"/> ** Corporation	<input type="checkbox"/> City/County
<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> *** Limited Liability Company	<input type="checkbox"/> Hospital District
_____	<input type="checkbox"/> Other (specify) _____	<input type="checkbox"/> Federal
_____	_____	<input type="checkbox"/> Other (specify) _____

*If a Limited Partnership, submit a copy of the "Application For Registration" and "Certificate of Registration" signed by the Indiana Secretary of State.

**If a Corporation, submit a copy of the "Articles of Incorporation" and "Certificate of Incorporation" signed by the Indiana Secretary of State. If a foreign Corporation, submit a copy of the "Certificate to do Business in the State of Indiana" signed by the Indiana Secretary of State.

***If a Limited Liability Company, submit a copy of the "Articles of Organization" and the "Certificate of Organization" signed by the Indiana Secretary of State.

SECTION V - DISCLOSURE OF APPLICANT ENTITY

A. Officers/Directors/Members/Partners/Managers

1. List all individuals (persons) associated with the applicant entity and indicate the individual's title (i.e. officer, director, member, partner, etc). If the applicant is a partnership, list the name and title of each partner or the name and title of all individuals associated with each entity that forms the partnership. If the applicant is a Limited Liability Company, list the name and title for all individuals associated with each member entity that forms the Limited Liability Company. *(use additional sheet if necessary)*

Name	Title	Business Address	Telephone Number

2. Are any individuals (persons) associated with the applicant entity (as listed in Sections IV.B and V.A.1) also associated with any other entity operating health facilities in Indiana or any other states? ☐ Yes ☐ No

If "yes," list names and addresses of facilities owned by each individual. *(use additional sheet if necessary)*

Facility Name	Address	City, County, State, Zip Code

3. Is the licensee (applicant) a lease entity? ☐ Yes ☐ No

If yes, explain _____

Please submit a copy of the lease showing an effective date. If this is a sublease or assignment of interest of a lease, submit a copy of all Leases affected by this transaction.

4. Is the applicant a subsidiary of another entity or corporation or does the applicant have subsidiaries under its control? ☐ Yes ☐ No
(If yes, list each entity (affiliated entity) on a separate sheet and explain the relationship)

B. Licensure/Operating History

Are any of the individuals (as listed in Sections IV.B. and V.A.1.), associated with or have they been associated with, any other entity that is operating, or has operated, health facilities in Indiana or any other state, that:

1. Has/had a record of operation of less than a full license (i.e. three month probationary, provisional, etc)

☐ Yes ☐ No *(If "Yes", provide name of facility, state, date(s), restrictions and type)*

2. Had a facility's license revoked, suspended or denied. ☐ Yes ☐ No *(If "Yes", provide name of facility, state, type of actions and date(s))*

3. Was the subject of decertification, termination, or had a finding of patient abuse, mistreatment or neglect.

☐ Yes ☐ No *(If "Yes", provide name of facility, state, date, type of action, results of action)*

4. Had a survey finding of Substandard Quality of Care or Immediate Jeopardy ☐ Yes ☐ No *(If "Yes", provide all correspondence and deficiency reports, including the current or final resolution of the matter)*

5. Filed for bankruptcy, reorganization or receivership. ☐ Yes ☐ No *(If "Yes", include all relevant documentation and provide a detailed summary of the events and circumstances. Include state, dates and names of facilities)*

NOTE: If any of the answers above are "Yes", list each facility on a separate sheet of paper and explain the facts clearly and concisely.

SECTION VI - CERTIFICATION OF APPLICATION

I hereby certify that the operational policies of the health facility will not provide for discrimination based upon race, color, creed or national origin.

I swear or affirm that all statements made in this application and any attachments thereto are correct to the best of my knowledge and that the applicant entity will comply with all laws, rules and regulations governing the licensing of health facilities in Indiana.

Applicant's signature, as indicated in V-A of this application, or signature of applicant's agent should appear below.

IF SIGNED BY ANY INDIVIDUAL (EG., THE ADMINISTRATOR) OTHER THAN INDICATED IN SECTION V.A.1. OF THIS APPLICATION, AN AFFIDAVIT MUST BE SUBMITTED WITH THE APPLICATION AFFIRMING THAT SAID PERSON HAS BEEN GIVEN THE POWER TO BIND THE APPLICANT/LICENSEE.

Name of Authorized Representative (*Typed*)

Title

Signature

Date

STATE OF _____

COUNTY OF _____

Subscribed and sworn to before me, a Notary Public, for _____ County, State of _____,
this _____ day of _____, 20_____

(SEAL)

(Signature) _____

_____, Notary Public
(Type or Print Name)

My Commission expires _____



IMPLEMENTING INDIANA CODE 16-28-2-6

State Form 19733 (R4/11-00)

Indiana State Department of Health-Division of Long Term Care

PLEASE READ BEFORE COMPLETING THIS FORM

IC 16-28-2-6 created a reporting requirement for some facilities which charge certain fees and have a name which implies association with a religious, charitable, or other nonprofit organization.

This form was developed and approved by the Indiana Health Facilities Council in order to obtain the information required by law. Please read the attached form carefully. If your facility is **not** one of those included in the category affected by this law, you need only check the appropriate box in Section A, have the form notarized, signed by the appropriate person, and return it with your application.

If you **are** included in the category affected, read and follow the directions, have the form notarized, signed by the appropriate person and return it with your application.

The information required on this form is necessary in order for a health facility to be licensed.

Name of Facility

Street Address

City

State

Zip+4

SECTION A

This health facility ☐ does ☐ does not have charges other than daily or monthly rates for room, board, and care consisting of a required admission payment of money or investment of money or other consideration for admission.

IF SECTION A ABOVE IS ANSWERED IN THE NEGATIVE, SKIP TO SECTION F BELOW

SECTION B

The name of this health facility or the name of the person operating the health facility ☐ does ☐ does not imply affiliation with a religious, charitable, or other nonprofit organization.

SECTION C

Is this health facility affiliated with a religious, charitable, or other nonprofit organization? ☐ yes ☐ no

SECTION D

If Section C was answered "yes", list the nature and extent of such affiliation, including the name of such affiliated organization, its address, and the extent, if any, to which it is responsible for the financial and contractual obligations of the health facility. (This material, if lengthy, may be submitted as an attachment. Attachments must be numbered and referenced on lines provided below.)

SECTION E

Unless Sections B and C above are answered in the negative, complete this Section, and **NOTE THE OBLIGATIONS OF HEALTH FACILITY**

1. The health facility hereby agrees that all health facility's advertisements and solicitations shall include a summary statement disclosing any affiliation between the health facility and the religious, charitable, or other nonprofit organization; and the extent, if any, to which the affiliated organizations is responsible for the financial and contractual obligations of the health facility. **Please attach the summary statement.** If not attached, explain why not, and if, an when, it will be furnished.
2. The health facility shall furnish each prospective resident with a disclosure statement as contemplated by Indiana law. **Please attach the disclosure statement.** If not attached, explain why not, and if, and when, it will be furnished.

SECTION F

THE HEALTH FACILITY HEREBY AGREES THAT, WHENEVER THERE IS A CHANGE IN ITS ACTUAL OR IMPLIED AFFILIATION WITH A RELIGIOUS, CHARITABLE OR NONPROFIT ORGANIZATION, AND THE FACILITY HAS ADMISSION CHARGES OTHER THAN DAILY OR MONTHLY RATES FOR ROOM, BOARD, AND CARE, THEN THE FACILITY WILL PREPARE OR AMEND A SUMMARY STATEMENT, AND THE DISCLOSURE STATEMENT, IF THAT IS NECESSARY UNDER THE PROVISIONS OF INDIANA CODE 16-28-2-6, AND IMMEDIATELY FILE SUCH PREPARED STATEMENT(S) WITH THE INDIANA HEALTH FACILITIES COUNCIL.

I affirm, under the penalties of perjury, that the information and undertakings set out above are made in good faith, true, and complete, to the best of my knowledge and belief, and that the person signing the foregoing form is the duly authorize representative of the health facility for that purpose.

Board Chairman or Owner

Print Name of Signer

STATE OF _____)

COUNTY OF _____)

Subscribed and sworn to before me, this _____ day of _____, 20_____

(Seal)

Notary Public

County of Residence

My commission expires _____

PLEASE RETURN FORM TO:

Indiana State Department of Health
Division of Long Term Care
2 North Meridian Street, Section 4-B
Indianapolis, IN 46204



**INDEPENDENT VERIFICATION
OF ASSETS AND LIABILITIES**

State Form 51996 (R1/6-05)

Indiana State Department of Health-Division of Long Term Care
(Pursuant to IC 16-28, IAC 16.2-3.1-2 and 410 IAC 16.2-5-1.1)

INSTRUCTIONS:

Licensee: <ol style="list-style-type: none">1. Complete sections I, II, and section III, F and G.2. Attach any documentation used to complete the information. Include the method used to determine projection of revenue and operating expenses, in order to complete the application process.3. Forward the completed materials to a Certified Public Accountant.4. Upon return from the CPA, sign and date the certification statement in section V (Licensee) and include the entire set of documents with the completed application.	CPA: <ol style="list-style-type: none">1. Complete sections III, A, B, C, D, and E by A. using an audit, review, or compilation completed within the preceding twelve months, or B. performing a financial compilation.2. Using agreed upon procedures; verify items in section IV, F.3. Sign and date the certification statement as indicated in Section IV (CPA).4. Attach the compilation and agreed upon procedures report to this form and return to the Licensee.
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Please Type or Print Legibly

SECTION I – TYPE OF APPLICATION

Application (check appropriate item)

☐ **Change of Ownership** (Anticipated date of Sale/Purchase/Lease: _____) ☐ **New Facility** ☐ **Other** _____

SECTION II - IDENTIFYING INFORMATION

A. Physical Location (facility)

Name of Facility:

Street Address

City

County

Zip Code +4

Telephone Number

Fax Number

Facility's Cost Reporting Year

()

()

From (mm/dd)

To (mm/dd):

B. Licensee/Ownership Information

Licensee (Operator(s) of the facility) Same as Licensee on Application for License to Operate a Health Facility, Section B

Street Address

P.O. Box

City

State

Zip Code + 4

SECTION III – SELECTED BALANCE SHEET ITEMS AS OF _____ (date)			
A. Current Assets:		B. Current Liabilities:	
<i>Asset</i>	<i>Amount (rounded to nearest dollar)</i>	<i>Liability</i>	<i>Amount (rounded to nearest dollar)</i>
Cash		Accounts Payable	
Accounts Receivable		Other Current Liabilities	
Less: Allowance for bad debt		Intercompany Liabilities	
Prepaid Expenses		Non-related Party Working Capital Loans	
Inventories and Supplies		Related Party Working Capital	
Intercompany Receivables		Other Current Liabilities	
All Loans to Owners, Officers & Related Parties		Total Current Liabilities	
Assets Held for Investment			
Other Current Assets			
Total Current Assets			
C. Working Capital: (Total Current Assets minus Total Current Liabilities) \$ _____			
D. Total Liabilities: \$ _____		E. Total Owner's Equity or Fund Balance: \$ _____	
F. Lines of Credit (List all letters of credit or other open lines of credit available, attach additional sheet(s) if necessary):			
<u>Name of Institution or Lender</u>		<u>Amount of Credit Available</u>	
1.		\$	
2.		\$	
3.		\$	
4.		\$	
G. Number of Facility Beds: _____ Projected Monthly Revenue: \$ _____ Projected Monthly Operating Expenses: \$ _____			
SECTION IV – CERTIFICATION STATEMENTS			
<i>Under penalty of perjury: I certify that the foregoing information, including any attached exhibits, schedules, and explanations is true, accurate, and complete. Having reviewed each section, together with the identified attachments, I am satisfied that each section is correctly answered and that the answers and any attachments are sufficient in scope and clarity to accomplish full disclosure (full disclosure requires that a knowledgeable financial reader, after reviewing the explanations and attachments, would not be misled). I understand that any false claims, statements, or documents, or concealment of material fact may be prosecuted under applicable federal or state law.</i>			
Name of Authorized Person (Typed)		Title/Position	
Signature of Authorized Person		Date	
<i>This is to confirm that I (we) have prepared a compilation of financial information which is the basis for the data indicated in sections A through E inclusive, and have verified the existence of the lines of credit listed in section F, pursuant to agreed upon procedures between myself(us) and the licensee(s) listed herein (see attached compilation and agreed upon procedures report).</i>			
Name of Certified Public Accountant representing the firm (Typed)		Title/Position	
Signature of Certified Public Accountant representing the firm		License/Certification Number	Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey

From: F1 To: F2
MM DD YY MM DD YY

Extended Survey

From: F3 To: F4
MM DD YY MM DD YY

Name of Facility		Provider Number		Fiscal Year Ending: F5 <input type="text"/> <input type="text"/> <input type="text"/> MM DD YY	
Street Address	City	County	State	Zip Code	
Telephone Number: F6		State/County Code: F7		State/Region Code: F8	

A. F9 ☐ ☐

- 01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☐

If yes, indicate Hospital Provider Number: F11

Ownership: F12 ☐ ☐

For Profit

- 01 Individual
02 Partnership
03 Corporation

NonProfit

- 04 Church Related
05 Nonprofit Corporation
06 Other Nonprofit

Government

- 07 State
08 County
09 City
10 City/County
11 Hospital District
12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☐

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

- | | |
|---|---|
| F15 <input type="text"/> <input type="text"/> <input type="text"/> AIDS | F16 <input type="text"/> <input type="text"/> <input type="text"/> Alzheimer's Disease |
| F17 <input type="text"/> <input type="text"/> <input type="text"/> Dialysis | F18 <input type="text"/> <input type="text"/> <input type="text"/> Disabled Children/Young Adults |
| F19 <input type="text"/> <input type="text"/> <input type="text"/> Head Trauma | F20 <input type="text"/> <input type="text"/> <input type="text"/> Hospice |
| F21 <input type="text"/> <input type="text"/> <input type="text"/> Huntington's Disease | F22 <input type="text"/> <input type="text"/> <input type="text"/> Ventilator/Respiratory Care |
| F23 <input type="text"/> <input type="text"/> <input type="text"/> Other Specialized Rehabilitation | |

Does the facility currently have an organized residents group?	F24	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the facility currently have an organized group of family members of residents?	F25	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does the facility conduct experimental research?	F26	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes <input type="checkbox"/>	No <input type="checkbox"/>

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: F28 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hours waived per week: F29 _____
Waiver of 24 hr licensed nursing requirement.	Date: F30 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Hours waived per week: F31 _____
	MM DD YY	

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☐

FACILITY STAFFING

	Tag Number	A			B				C				D			
		Services Provided			Full-Time Staff (hours)				Part-Time Staff (hours)				Contract (hours)			
		1	2	3												
Administration	F33															
Physician Services	F34															
Medical Director	F35															
Other Physician	F36															
Physician Extender	F37															
Nursing Services	F38															
RN Director of Nurses	F39															
Nurses with Admin. Duties	F40															
Registered Nurses	F41															
Licensed Practical/ Licensed Vocational Nurses	F42															
Certified Nurse Aides	F43															
Nurse Aides in Training	F44															
Medication Aides/Technicians	F45															
Pharmacists	F46															
Dietary Services	F47															
Dietitian	F48															
Food Service Workers	F49															
Therapeutic Services	F50															
Occupational Therapists	F51															
Occupational Therapy Assistants	F52															
Occupational Therapy Aides	F53															
Physical Therapists	F54															
Physical Therapists Assistants	F55															
Physical Therapy Aides	F56															
Speech/Language Pathologist	F57															
Therapeutic Recreation Specialist	F58															
Qualified Activities Professional	F59															
Other Activities Staff	F60															
Qualified Social Workers	F61															
Other Social Services	F62															
Dentists	F63															
Podiatrists	F64															
Mental Health Services	F65															
Vocational Services	F66															
Clinical Laboratory Services	F67															
Diagnostic X-ray Services	F68															
Administration & Storage of Blood	F69															
Housekeeping Services	F70															
Other	F71															

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility

For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey - LEAVE BLANK - Survey team will complete

Extended Survey - LEAVE BLANK - Survey team will complete

INSTRUCTIONS AND DEFINITIONS

Name of Facility - Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number - Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address - Street name and number refers to physical location, not mailing address, if two addresses differ.

City - Rural addresses should include the city of the nearest post office.

County - County refers to parish name in Louisiana and township name where appropriate in the New England States.

State - For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code - Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number - Include the area code.

State/County Code - LEAVE BLANK - State Survey Office will complete.

State/Region Code - LEAVE BLANK - State Survey Office will complete.

Block F9 - Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10 - If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11 - The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12 - Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

FOR PROFIT - If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

NONPROFIT - If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

GOVERNMENT - If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13 - Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no." A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14 - If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23 - Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24 - Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25 - Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Block F26 - Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27 - Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31 - If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.30(c) or (d), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32 - Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."

Column A-1 - Refers to those services provided onsite to residents, either by employees or contractors.

Column A-2 - Refers to those services provided onsite to non-residents.

Column A-3 - Refers to those services provided to residents offsite/or not routinely provided onsite.

Column B - Full-time staff, C - Part-time staff, and D - Contract - Record hours worked for each field of full-time staff, part-time staff, and contract staff (do not include meal breaks of a half an hour or more). Full-time is defined as 35 or more hours worked per week. Part-time is anything less than 35 hours per week. Contract includes individuals under contract (e.g., a physical therapist) as well as organizations under contract (e.g., an agency to provide nurses). If an organization is under contract, calculate hours worked for the individuals provided. Lines blocked out (e.g., Physician services, Clinical labs) do not have hours worked recorded.

REMINDER - Use a 2-week period to calculate hours worked.

FACILITY STAFFING

GENERAL INSTRUCTIONS

This form requires you to identify whether certain services are provided and to specify the number of hours worked providing those services. Column A requires you to enter "yes" or "no" about whether the services are provided onsite to residents, onsite to nonresidents, and offsite to residents. Columns B-D requires you to enter the specific number of hours worked providing the service. To complete this section, base your calculations on the staff hours worked in the most recent complete pay period. If the pay period is more than 2 weeks, use the last 14 days. For example, if this survey begins on a Tuesday, staff hours are counted for the previous complete pay period.

Definition of Hours Worked - Hours are reported rounded to the nearest whole hour. Do not count hours paid for any type of leave or non-work related absence from the facility. If the service is provided, but has not been provided in the 2-week pay period, check the service in Column A, but leave B, C, or D blank. If an individual provides service in more than one capacity, separate out the hours in each service performed. For example, if a staff person has worked a total of 80 hours in the pay period but has worked as an activity aide and as a Certified Nurse Aide, separately count the hours worked as a CNA and hours worked as an activity aide to reflect but not to exceed the total hours worked within the pay period.

Completion of Form

Column A - Services Provided - Enter Y (yes), N (no) under each sub-column. For areas that are blocked out, do not provide the information.

DEFINITION OF SERVICES

Administration - The administrative staff responsible for facility management such as the administrator, assistant administrator, unit managers and other staff in the individual departments, such as: Health Information Specialists (RRA/ARTI), clerical, etc., who do not perform services described below. Do not include the food service supervisor, housekeeping services supervisor, or facility engineer.

Physician Services - Any service performed by a physician at the facility, except services performed by a resident's personal physician.

Medical Director - A physician designated as responsible for implementation of resident care policies and coordination of medical care in the facility.

Other Physician - A salaried physician, other than the medical director, who supervises the care of residents when the attending physician is unavailable, and/or a physician(s) available to provide emergency services 24 hours a day.

Physician Extender - A nurse practitioner, clinical nurse specialist, or physician assistant who performs physician delegated services.

Nursing Services - Coordination, implementation, monitoring and management of resident care plans. Includes provision of personal care services, monitoring resident responsiveness to environment, range-of-motion exercises, application of sterile dressings, skin care, naso-gastric tubes, intravenous fluids, catheterization, administration of medications, etc.

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Director of Nursing - Professional registered nurse(s) administratively responsible for managing and supervising nursing services within the facility. Do not additionally reflect these hours in any other category.

Nurses with Administrative Duties - Nurses (RN, LPN, LVN) who, as either a facility employee or contractor, perform the Resident Assessment Instrument function in the facility and do not perform direct care functions. Also include other nurses whose principal duties are spent conducting administrative functions. For example, the Assistant Director of Nursing is conducting educational/in-service, or other duties which are not considered to be direct care giving. Facilities with an RN waiver who do not have an RN as DON report all administrative nursing hours in this category.

Registered Nurses - Those persons licensed to practice as registered nurses in the State where the facility is located. Includes geriatric nurse practitioners and clinical nurse specialists who primarily perform nursing, not physician-delegated tasks. Do not include Registered Nurses' hours reported elsewhere.

Licensed Practical/Vocational Nurses - Those persons licensed to practice as licensed practical/vocational nurses in the State where the facility is located. Do not include those hours of LPN/LVNs reported elsewhere.

Certified Nurse Aides - Individuals who have completed a State approved training and competency evaluation program, or competency evaluation program approved by the State, or have been determined competent as provided in 483.150(a) and (3) and who are providing nursing or nursing-related services to residents. Do not include volunteers.

Nurse Aides in Training - Individuals who are in the first 4 months of employment and who are receiving training in a State approved Nurse Aide training and competency evaluation program and are providing nursing or nursing-related services for which they have been trained and are under the supervision of a licensed or registered nurse. Do not include volunteers.

Medication Aides/Technicians - Individuals, other than a licensed professional, who fulfill the State requirement for approval to administer medications to residents.

Pharmacists - The licensed pharmacist(s) who a facility is required to use for various purposes, including providing consultation on pharmacy services, establishing a system of records of controlled drugs, overseeing records and reconciling controlled drugs, and/or performing a monthly drug regimen review for each resident.

Dietary Services - All activities related to the provision of a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident.

Dietitian - A person(s), employed full, part-time or on a consultant basis, who is either registered by the Commission of Dietetic Registration of the American Dietetic Association, or is qualified to be a dietitian on the basis of experience in identification of dietary needs, planning and implementation of dietary programs.

Food Service Workers - Persons (excluding the dietitian) who carry out the functions of the dietary service (e.g., prepare and cook food, serve food, wash dishes). Includes the food services supervisor.

Therapeutic Services - Services, other than medical and nursing, provided by professionals or their assistants, to enhance the residents' functional abilities and/or quality of life.

Occupational Therapists - Persons licensed/registered as occupational therapists according to State law in the State in which the facility is located. Include OTs who spend less than 50 percent of their time as activities therapists.

Occupational Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Occupational Therapist (OT) to carry out the OT's comprehensive plan of care, without the direct supervision of the therapist. Include OT Assistants who spend less than 50 percent of their time as Activities Therapists.

Occupational Therapy Aides - Person(s) who have specialized training to assist an OT to carry out the OT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Physical Therapists - Persons licensed/registered as physical therapists, according to State law where the facility is located.

Physical Therapy Assistants - Person(s) who, in accord with State law, have licenses/certification and specialized training to assist a licensed/certified/registered Physical Therapist (PT) to carry out the PT's comprehensive plan of care, without the direct supervision of the PT.

Physical Therapy Aides - Person(s) who have specialized training to assist a PT to carry out the PT's comprehensive plan of care under the direct supervision of the therapist, in accord with State law.

Speech-Language Pathologists - Persons licensed/registered, according to State law where the facility is located, to provide speech therapy and related services (e.g., teaching a resident to swallow).

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

Therapeutic Recreation Specialist - Person(s) who, in accordance with State law, are licensed/registered and are eligible for certification as a therapeutic recreation specialist by a recognized accrediting body.

Qualified Activities Professional - Person(s) who meet the definition of activities professional at 483.15(f)(2)(i)(A) and (B) or 483.15(f)(2)(ii) or (iii) or (iv) and who are providing an on-going program of activities designed to meet residents' interests and physical, mental or psychosocial needs. Do not include hours reported as Therapeutic Recreation Specialist, Occupational Therapist, OT Assistant, or other categories listed above.

Other Activities Staff - Persons providing an on-going program of activities designed to meet residents' needs and interests. Do not include volunteers or hours reported elsewhere.

Qualified Social Worker(s) - Person licensed to practice social work in the State where the facility is located, or if licensure is not required, persons with a bachelor's degree in social work, a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling and psychology, and one year of supervised social work experience in a health care setting working directly with elderly individuals.

Other Social Services Staff - Person(s) other than the qualified social worker who are involved in providing medical social services to residents. Do not include volunteers.

Dentists - Persons licensed as dentists, according to State law where the facility is located, to provide routine and emergency dental services.

Podiatrists - Persons licensed/registered as podiatrists, according to State law where the facility is located, to provide podiatric care.

Mental Health Services - Staff (excluding those included under therapeutic services) who provide programs of services targeted to residents' mental, emotional, psychological, or psychiatric well-being and which are intended to:

- Diagnose, describe, or evaluate a resident's mental or emotional status;
- Prevent deviations from mental or emotional well-being from developing; or
- Treat the resident according to a planned regimen to assist him/her in regaining, maintaining, or increasing emotional abilities to function.

Among the specific services included are psychotherapy and counseling, and administration and monitoring of psychotropic medications targeted to a psychiatric diagnosis.

Vocational Services - Evaluation and training aimed at assisting the resident to enter, re-enter, or maintain employment in the labor force, including training for jobs in integrated settings (i.e., those which have both disabled and nondisabled workers) as well as in special settings such as sheltered workshops.

Clinical Laboratory Services - Entities that provide laboratory services and are approved by Medicare as independent laboratories or hospitals.

Diagnostic X-ray Services - Radiology services, ordered by a physician, for diagnosis of a disease or other medical condition.

Administration and Storage of Blood Services - Blood bank and transfusion services.

Housekeeping Services - Services, including those of the maintenance department, necessary to maintain the environment. Includes equipment kept in a clean, safe, functioning and sanitary condition. Includes housekeeping services supervisor and facility engineer.

Other - Record total hours worked for all personnel not already recorded, (e.g., if a librarian works 10 hours and a laundry worker works 10 hours, record 00020 in Column C).

ASSURANCE OF COMPLIANCE

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, AND THE AGE DISCRIMINATION ACT OF 1975

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified handicapped individual in the United States shall, solely by reason of his handicap, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Educational Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The person or persons whose signature(s) appear(s) below is/are authorized to sign this assurance, and commit the Applicant to the above provisions.

Date

Signature and Title of Authorized Official

Name of Applicant or Recipient

Street

City, State, Zip Code

Mail Form to:
DHHS/Office for Civil Rights
Office of Program Operations
Humphrey Building, Room 509F
200 Independence Ave., S.W.
Washington, D.C. 20201

Form HHS-690
5/97

**BED INVENTORY**

State Form 4332 (R8/1-02)

Indiana State Department of Health-Division of Long Term Care

Name of Facility													
Street Address													
City					County				Zip+4				
PLEASE SPECIFY THE NUMBER OF BEDS IN EACH ROOM AS FOLLOWS: Each room should be listed only once and listed in numerical order under each classification column.										Room No.		No. Beds	
Title 18 SNF = Medicare ONLY beds Title 18 SNF/NF 19 NF = Medicare/Medicaid (Dually Certified) Title 19 NF = Medicaid All licensed beds must be listed.										8		2	
										9		2	
										10		2	
										11		3	
										12		2	
NCC = Non-Certified Comprehensive Residential Level of Care										20		2	
Title 18 SNF		Title 18/19 SNF/NF		Title 19 NF				NCC		Residential			
Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds	Room #	# Beds		
Total 18 SNF		Total 18/19 SNF/NF		Total 19 NF				Total NCC		Total Residential			

Current SNF Census _____

Current SNF/NF Census _____

Current NF Census _____

Current NCC Census _____

Current Residential Census _____

TOTAL CURRENT CENSUS _____

TOTAL LICENSED CAPACITY _____

NOTE

Completion of this form is not an official bed change request or a change from those beds

Completed by	Position	Date
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